DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

Canc frp: Dec 2005
IN REPLY REFER TO

BUMEDNOTE 6310
BUMED–M3M2
3 Dec 2004

BUMED NOTICE 6310

From: Chief, Bureau of Medicine and Surgery

Subj: FY 2005 NAVY MEDICINE DISEASE STATE AND CONDITION MANAGEMENT PROGRAM

Ref: (a) FY 2005 BUMED Business Plan
(b) BUMED WASHINGTON DC 031210Z JUN 04 (NOTAL)

Encl: (1) Diabetes Mellitus Care
(2) Asthma Care
(3) Breast Health Initiative

1. Purpose. To define Navy Medicine system-wide expectations and guidance for the diabetes, asthma, and breast health disease state and condition management programs.

2. Background. Effective management of patients with targeted disease states and conditions improves patients' health and reduces health care costs. Condition management has shown positive returns on investment in a number of conditions studied including asthma and diabetes.

3. Action

a. Targeted disease states and conditions are contained in reference (a), available at: https://dataqualiy.med.navy.mil/community/default.aspx and are actionable for all military treatment facilities (MTFs).

b. Each MTF will appoint a clinical champion and program coordinator for the disease states and conditions contained herein to implement enclosures (1) through (3) at the local level. These individuals shall be identified with contact information sent to BUMED-M3M2 within 30 days of the date of this notice. POC is LCDR Ron Gimbel at (202) 762-1651, DSN 762-1615 or e-mail to rwgimbel@us.med.navy.mil.

c. Per reference (b), Population Health Navigator (PHN) is the clinical information system for Navy Medicine's disease and condition management initiatives. MTFs shall identify clinic managers or appropriate personnel to monitor PHN data and coordinate patient action lists. This notice does not preclude commands from using additional clinical information resources to track and manage targeted disease states.

4. Points of Contact

a. For PHN account access contact BUMED Clinical Operations Division at (202) 762-0966, DSN 762-0966, or e-mail to phn.admin@us.med.navy.mil.

b. For general population health assistance contact LCDR Annette M. Von Thun at (757) 953-0970, DSN 377-0970, or e-mail to vonthuna@nehc.med.navy.mil.

5. Cancellation Contingency. Cancelled upon issuance of FY 2006 guidance.

D. C. ARTHUR

Distribution:
SNDL, C28G (BRDENCLINIC)
C28H (BRMEDCLINIC)
C31J (BRMEDCLINIC)
C34F (BRMEDCLINIC)
C34G (BRDENCLINIC)
C52 (BUMED SHORE BASED DETACHMENTS)
C58Q (BRDENCLINIC)
C58R (BRMEDCLINIC)
C85A (BRMEDCLINIC)
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FB60 (NAVMEDCLINIC)
FC16 (NAVMEDCLINIC)
FC17 (NAVHOSP)
FF72 (NAVMEDCLINIC)
FH (BUMED COMMAND ACTIVITIES)
FT108 (NAVHOSP)
FW1 (NATNAVMEDCEN)
FW2 (NATNAVDENCEN)
FW4 (NAVMEDCLINIC)

Available at: http://navymedicine.med.navy.mil/default.cfm?seltab=directives

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DIABETES MELLITUS CARE

1. Background. Diabetes mellitus is a disease state prevalent in all Navy Medicine MTFs. Many diabetic patients additionally suffer comorbidities including heart disease, hypertension, hyperlipidemia, and stroke. Effective care management of diabetic patients improves health outcomes and reduces health care expenditures.

2. Standards. Optimal diabetic management includes general assessment, addressing control of HbA1C and LDL-cholesterol, controlling blood pressure, screening for retinopathy/nephropathy, providing patient education and periodic follow-up. The following standards shall apply to all MTFs:

a. Identification of Diabetes Cohort: All MTFs shall identify their enrolled patients diagnosed with diabetes and take action to manage their care. The Population Health Navigator (PHN) information tool contains a list of enrolled diabetics.

b. Clinical Practice Guideline: All MTFs shall implement an existing clinical practice guideline for diabetes care. Recommended guidelines, with accompanying evidence review, are available at: https://dataquality.med.navy.mil/Community/Clinical/Disease/+Management/default.aspx.

c. Disease Management Re-engineering: Navy Medicine recognizes the value of caring for diabetic patients in both primary care-centered clinics and diabetes-focused clinics. Regardless of the structure selected, each MTF should consider what successful programs have found to be essential including:

(1) Mapping out and optimizing clinical and business processes for the care of diabetic patients. These processes should include, among others:

(a) Identification of diabetic patients having HbA1c levels exceeding $\geq$ 9.0% to evaluate for more intensive management.

(b) Notification of primary care manager (PCM) after a diabetic patient is seen in the emergency department (ED).

(c) A 24-hour telephonic access to primary care for diabetic patients.

(2) Training all members of the health care team on their respective roles and responsibilities. Commands should conduct initial and ongoing training on basic skill competencies for team members.

d. Patient Education: Each MTF shall implement a culturally sensitive comprehensive educational process for all diabetic patients and their families. Recommended materials are available in the Diabetes Champion Toolbox at: https:// dataquality.med.navy.mil/Community/Clinical/Disease+Management/default.aspx.

3. Metrics. While commands may opt to track multiple measures associated with diabetic care, per reference (a) the following HEDIS® metrics are tracked centrally:

a. Percent of patients with HbA1c values less than or equal to 9.0%: Patients enrolled to the command with Type I or Type II diabetes, age 18-75 years, with HbA1c values $\leq$ 9.0% during the past year.

b. Percent of patients with LDL-Cholesterol test values < 100 mg/dl: Patients enrolled to your MTF with Type 1 or Type 2 diabetes, age 18-75 years, with LDL-Cholesterol values < 100 mg/dl during the past year.

c. Data for these metrics will be obtained from the PHN clinical information system and may also be accessed via the BUMED Business Planning Tool. The data are also displayed in dashboard format to allow comparisons with other MTFs, Navy averages and national HEDIS benchmarks. These graphs are available at: https://dataquality. med.navy.mil/reconcile/pophealth/.

4. Diabetes Champion Toolkit. Navy Medicine's Diabetes Action Team has developed and launched a Diabetes Champion Toolkit at: https://dataquality.med.navy.mil/ Community/Clinical/Disease+Management/default.aspx. The toolkit includes several recommended clinical guidelines, patient and health care team educational materials and other useful resources and tools.

5. Request for Assistance. For assistance with resources or with implementation of population health initiatives contact your local Healthcare Support Office representative or Navy Environmental Health Center (NEHC) Population Health Directorate. POC is LCDR Annette M. Von Thun at (757) 953-0970, DSN 377-0970 or e-mail to vonthuna@nehc.med.navy.mil.

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ASTHMA CARE

1. Background. Asthma is a chronic respiratory disease that places a notable burden on those affected and results in substantial morbidity and health care utilization. Within the Navy Medicine direct care system, patients with persistent asthma, but who are not on a long-term controller medication, have over a ten-fold higher ED utilization and inpatient admission rate than persistent asthma patients on a long-term controller medication.

2. Standards. Optimal asthma management includes appropriate assessment and therapy, providing patient education, and assuring follow-up especially after ED visits and admissions. The following standards shall apply to all MTFs:

a. Identification of Asthma Cohort: All MTFs shall identify their enrolled patients diagnosed with asthma and take action to manage their care. The Population Health Navigator (PHN) information tool contains a list of MTF-enrolled asthmatics.

b. Clinical Practice Guideline: All MTFs shall implement an existing clinical practice guideline for asthma care. Recommended guidelines, with accompanying evidence review are available on the Asthma Champion Toolkit at: https://dataquality.med.navy.mil/Community/Clinical/Disease+Management/default.aspx

c. Asthma Management Re-engineering: Navy Medicine recognizes the value of caring for asthma patients in both primary care-centered clinics and asthma-focused clinics. Regardless of the structure selected, each MTF should consider what successful programs have found to be essential including:

(1) Mapping out and optimizing clinical and business processes for the care of asthma patients. These processes should include, among others:

(a) Identification and understanding of why enrolled persistent asthma patients are not currently on long-term controller medications, particularly inhaled corticosteroids.

(b) Notification of primary care manager (PCM) within 24-hours after a patient is seen for asthma in the ED.

(c) 24-hour telephonic access to primary care for patients with asthma.

(2) Training all members of the health care team on their respective roles and responsibilities. Commands should conduct initial and ongoing training on basic skill competencies for team members.

d. Patient Education: Each MTF shall implement a culturally sensitive comprehensive asthma education process. Recommended materials are available in the Asthma Champion Toolkit available at: https://dataquality.med.navy.mil/ Community /Clinical/Disease+Management/default.aspx.

3. Metrics. While commands may opt to track multiple measures associated with asthma care, per reference (a) the following HEDIS® metric is tracked centrally:

a. Percent of patients, continuously enrolled for the past two years, ages 5 – 56 years, with persistent asthma who had at least one prescription during the last 12 months for one of the following medications: inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers, and methylxanthines.

b. Data for this metric will be obtained from the PHN clinical information system and may also be accessed via the BUMED Business Planning Tool. The data are also displayed in dashboard format to allow comparisons with other MTFs, Navy averages and national HEDIS benchmarks. These graphs are available at: https://dataquality. med.navy.mil/reconcile/pophealth/.

4. Asthma Champion Toolkit. Navy Medicine's Asthma Action Team has developed and launched an Asthma Champion Toolkit available at: https://dataquality.med.navy. mil/Community/Clinical/Disease+Management/default.aspx. The toolkit includes several recommended clinical guidelines, patient and health care team educational materials, and other useful resources and tools.

5. Request for Assistance. For assistance with resources or with implementation of asthma disease management initiatives contact your local Healthcare Support Office representative or CAPT Henry Wojtczak at (619) 532-6883, DSN 522-6883 or e-mail to hawojtczak@nmcsd. med.navy.mil.

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BREAST HEALTH INITIATIVE

1. Background. Breast cancer is the second leading cause of cancer-related death in women. Risk assessment and prevention are key elements in breast health care. Early detection improves an individual's prognosis. The U.S. Preventive Services Task Force (USPSTF) recommends that women age 40 and older receive breast cancer screening every 12-33 months with mammography and clinical breast examination. A systematic review of clinical trials concluded that mammography may reduce breast cancer mortality by 9 to 33 percent.

2. Standards. All MTFs are responsible for including breast health within their scope of practice. The following standards apply:

a. Identification of Cohort: All MTFs shall identify their enrolled female patients aged 40 and older and take proactive measures to manage their care. Although the HEDIS® breast cancer screening metric referenced below tracks only women 52-69 years old, women over 40 encompass the USPSTF-recommended screening group. The Action List in PHN for breast cancer screening includes women aged 40 to 69.

b. Clinical Practice Guideline: All MTFs shall implement a clinical process for breast health. Practice recommendations with accompanying evidence review are available at: https://dataquality.med.navy.mil/Community/Clinical/Disease+Management/default.aspx.

c. Breast Health Process Re-engineering: Regardless of on-site capability for conducting mammography, all MTFs should consider what successful programs have found to be essential including:

(1) Mapping out and optimizing clinical and business processes for the care and/or referral of these patients.

(a) Identification and notification of enrolled women who are not obtaining their mammograms as recommended.

(b) Determination and remediation of process roadblocks that impede obtaining mammograms.

(2) Training members of the health care team on their respective roles and responsibilities.

d. Patient Education: Each MTF shall implement a culturally sensitive educational process for breast health.

3. Metrics. While commands may opt to track additional measures more closely associated with USPSTF recommendations on screening mammography, per reference (a) the following HEDIS® metric is tracked centrally:

a. Percent of women enrolled continuously for the past 12 months, ages 52 through 69 years, who received a mammogram in the past 24 months.

b. Data for this metric will be obtained from the PHN clinical information system and may also be accessed via the BUMED Business Planning Tool. The data are displayed in dashboard format to allow comparisons with other MTFs, Navy averages and national HEDIS benchmarks. These graphs are available at: https://dataquality.med.navy.mil/reconcile/pophealth/.

4. Breast Health Toolkit. Navy Medicine's Breast Health Initiative Advisory Board has developed and launched a Breast Health Toolkit at: https://dataquality.med.navy.mil/Community/Clinical/Disease+Management/default.aspx. The toolkit includes several recommended guidelines, patient and health care team educational materials, and other useful resources, tools and hyperlinks.

5. Request for Assistance. For general assistance and guidance relating to breast health, contact the BUMED Clinical Operations Division (M3M2). POC is CDR Peggy Sleichter, NC at (202) 762-3125, DSN: 762-3125 or e-mail to pmsleichter@us.med.navy.mil.